The Impact of HIV/AIDS Among Black Women in Virginia

Virginia Department of Health
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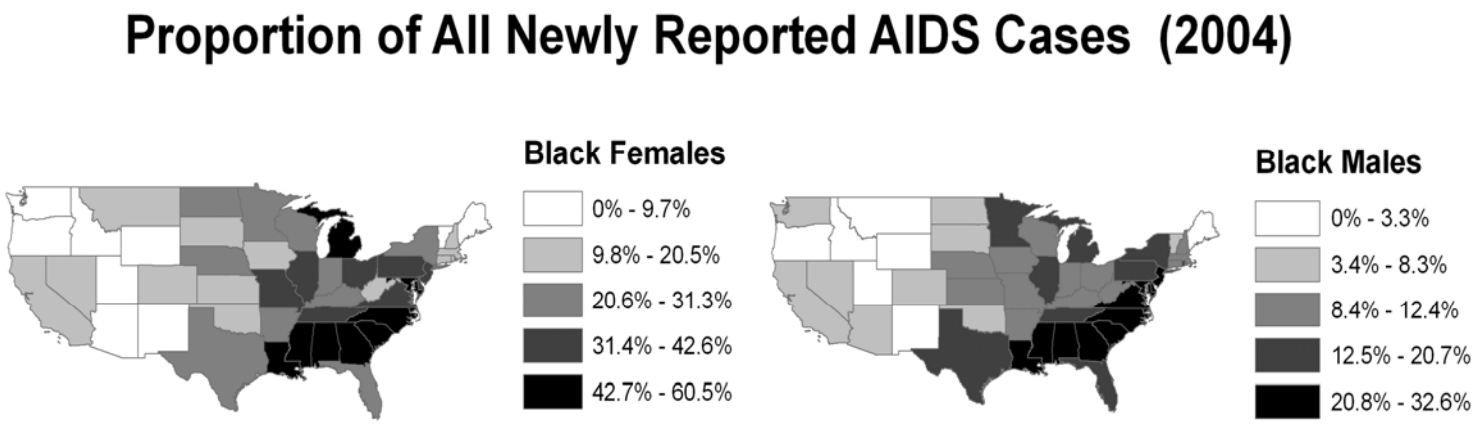
HIV has affected Black* women at disproportionate rates since the beginning of the HIV epidemic. This report describes the severity of the problem in Virginia, contributing factors to the high rates of infection among Black women, and current efforts to reduce HIV in this population.

Scope of the Problem

Black women constitute approximately 10% of Virginia's population but made up 21% of the new HIV cases reported in 2005. Men who have sex with men (MSM) still account for the largest number of reported HIV and AIDS cases in Virginia each year. Although the percentage of HIV cases reported annually among Black women in Virginia has not changed significantly over the past five years, in 2003, the prevalence rate of HIV in Black women in Virginia was 263 per 100,000 compared to 17 per 100,000 among White women. In addition, Black women in Virginia have been infected with HIV at approximately four times the rate of their White counterparts.[1]



Source: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Supplemental Reports, Volume 12, Number 2
Population Data: US Census Bureau, 2000
Note: Alaska, Hawaii, and the District of Columbia not shown

Virginia ranks 15th in the nation for the number of Blacks living with AIDS and 10th in the nation for the number of new AIDS cases among Blacks.[2] Nationally, the largest burden of new AIDS cases among both Black males and females is in the South.

*Throughout this document, both the term Black and African-American will be used. African-American is used to describe American-born Blacks and the corresponding cultural issues/research conducted among that population. When the term Black is used, it is inclusive of African-Americans, African immigrants and some people of Caribbean descent.

In 2002, HIV infection was the leading cause of death for Black women aged 25-34 years in the U.S.; the third leading cause of death for Black women aged 35-44 years and the fourth leading cause of death for Black women aged 45-54 years of age. Of the women living with HIV/AIDS in 2004, 64% were Black, 19% were White and 15% were Hispanic.[3]

Contributing Factors to Disparate Rates of HIV in Black Women

Male-to-female transmission of HIV is estimated to be eight times more likely than female-to-male.[4] Reasons for this are twofold: there are more men than women in the U.S. infected with HIV, which increases the likelihood that women would have an infected sex partner; and HIV is more easily transmitted from men to women.

Sexual abuse and coercion place many women at risk. In one study, physical and sexual abuse were "disturbingly common" throughout life among women at high risk for HIV infection. Childhood sexual abuse (42%) and physical abuse (42%) was also common. Women who have been abused are more likely to use crack cocaine and have multiple sex partners.[5] Crack cocaine and other mind/mood altering drugs, including alcohol, have been shown to impair judgment and increase sexual risk taking behaviors.

For women to protect themselves from HIV infection, they must not only rely on their own skills, attitudes, and behaviors regarding condom use, but also on their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making.[6]

Women are disproportionately represented among the poor. Because of this, women are less likely to have health insurance and access to health care services. Many minority women living in poverty are also disproportionately affected by HIV. For these women, the struggle for daily survival may take precedence over concerns about HIV infection, whose impact may not be seen for several years.[7]

Like many people in committed relationships, women may find intimacy in their relationship to be more important than protection against HIV. Unsafe sex may be linked to emotional and social (not necessarily financial) dependence on men. The ideal of monogamy, including assuming their partner's fidelity, may increase AIDS risk denial.[8]

Black women are disproportionately affected compared to other women for a variety of reasons. An in-depth study of 51 Black women, ages 18-49, living in Central Virginia was completed in 2004.[9] Twenty-three percent reported that their current sexual partner had been incarcerated and 28% reported that a past sexual partner had been incarcerated. Inmates have a rate of HIV infection that is three times higher than that of the general population.

Forty-three percent of the women in the study said they had not discussed safer sex with their current partner and 42% reported that they used alcohol in conjunction with sexual activity. Most striking is that 52% of the sample reported that they knew someone with HIV or AIDS but

perceived their own chances of getting HIV as "slim to none". This included some women who were aware of their partners' infidelity.

As noted above, domestic violence and sexual abuse can contribute to HIV risk taking behavior. Thirty-nine percent of the Black women in the Virginia study were exposed to domestic violence in their family of origin and 28% reported having suffered abuse or molestation growing up. One-third reported they had a past relationship with an abusive partner.

The majority of these women reported going to church regularly, both growing up and currently, and affirmed a great faith in God. These strong religious ties also led women to believe that "God will protect me from bad things", which may contribute to a false sense of protection regarding HIV.

A great deal of media attention has been focused on bi-sexual or "down-low" behavior among Black men that has placed Black women at risk for HIV. Clearly, this phenomenon is not new nor is it limited to the Black community. However, stronger religious prohibitions against homosexuality in the Black community may contribute to fewer men "coming out" and living as openly gay men. A 1998 Virginia study of men who have sex with men (MSM) showed that 39% of Black MSM reported having sex with a woman in the past three months compared to 10% of white men.[10] Sixty-five percent of White participants said they were exclusively attracted to men compared to only 34% of Black participants. The study also showed that Black men who were college graduates were less likely to disclose their sexual orientation to their families. The inverse was true for white men. The more education a white study participant had, the more likely he was to disclose to his family.

Unfortunately the "down low" issue has been over-sensationalized by the media and been used to place additional blame and stigma on Black men. The result is that the behavior of bisexual men may have been driven further underground, resulting in socially isolated men who engage in high-risk behaviors but are unlikely to participate in prevention activities targeted to them. The risk this poses for Black women has not been adequately addressed.

Numerous studies have also pointed to the social and sexual networks among African-Americans that create an environment of increased risk, which in turn contributes to higher rates of sexually transmitted diseases (STD) and HIV. In 2003, Blacks were approximately 19 times as likely to have gonorrhea and about six times as likely to have syphilis compared to Whites. Some STDs cause physical changes such as genital lesions that can serve as a port of entry for HIV. Having an STD increases the chances of contracting HIV by a 300% to 500%. Co-infection with HIV and an STD also increase the likelihood that the individual will transmit one or both infections to another person.[11]

African-Americans do not have more sexual partners than people of other races. A study in the Journal of the Sexually Transmitted Disease Association showed, however, that within African-American communities, people with few sexual partners are more likely to choose people with five or more sexual partners when choosing a new sex partner, compared to people of other races.[12] Thus, a Black individual may have no more sexual partners than another person but be placed at increased risk because of their partner's behavior. This is partially attributed to

the fact that the ratio of men to women is lower in the Black community than in any other racial/ethnic group due to a variety of factors including homicide, incarceration, etc. This impact can be observed locally. The City of Richmond has one of the highest historical levels of HIV incidence and among the lowest male to female ratios in the state.[1]

Finally, studies also show that Blacks are more likely to self-segregate and choose a partner of the same race and to choose a new partner from within their same social network.[13] Whites are more likely to choose a new partner from outside their social network. If one person within the Black social network has HIV or an STD, it is more likely that others in their social network will also become infected. These sociological factors demonstrate that it is not simply individual behavior that influences the disproportionate impact of HIV among Black women, but a complex social construct.

The social, environmental and cultural factors that place Black women at disproportionate risk for HIV also provide keys for HIV prevention. The Church, which plays an integral role in many Black women's lives, must be a partner and agent of change in addressing HIV among Black women. Programs must also address self worth, acknowledgement of personal risk and self-protective behaviors. The strength women draw from community can also be harnessed to establish norms around safer behaviors. Prevention programs should also have strong ties to services for women who have been abused or have been victims of violence. Finally, HIV will not be prevented among Black women unless prevention programs include and are targeted to Black men.

HIV Prevention Programs for Black Women in Virginia

Racial/ethnic minorities and high-risk heterosexuals are two of the seven priority populations established by the Virginia HIV Community Planning Committee, an advisory committee to the Virginia Department of Health's Division of Disease Prevention. From 2000 to 2004, the Division of Disease Prevention spent approximately 70% of its prevention budget targeting Blacks. Fifty percent of funds targeted high-risk heterosexuals, and 42% of all funds targeted Black women. The Division coordinates seven competitive grant programs that currently funds 40 contracts through 21 agencies. Most of the grant programs include a focus on people of color. The programs highlighted below include special emphasis in reaching Black women.

VDH established four Minority AIDS Projects (MAP) in 1988 to address disparities in HIV infection among communities of color. In 1995 that program was expanded to include seven localities. It was expanded once again in 2004. Minority community-based organizations in nine health districts are currently funded to target racial/ethnic minorities, primarily African-Americans, but also include African immigrants, Latinos and Asian Pacific Islanders. Projects are currently located in: Alexandria, Arlington, Crater, Fairfax, Peninsula, Norfolk, Richmond, Portsmouth, and Virginia Beach health districts. In 2005, over 89,000 people were reached through its programs. Annual funding for this program is $770,000. The MAPs represent the largest allocation for prevention services by grant program. A variety of interventions are utilized including street and community outreach, health communications, individual and group level education.

The Centers for Disease Control and Prevention (CDC) has strongly encouraged states to utilize prevention programs from the Diffusion of Effective Behavioral Interventions (DEBI) Project (www.effectiveinterventions.org). The DEBIs include HIV prevention interventions that have scientific evidence of effectiveness in reducing HIV risk behaviors. Virginia has successfully been implementing the DEBI ***SISTA*** since 2004. SISTA (Sisters Informing Sisters on Topics about AIDS) is a group-level, gender- and culturally- relevant intervention, designed to increase condom use among African-American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making followed by two booster sessions at three and six month intervals. The booster sessions provides an opportunity for women to receive support, encouragement and suggestions to address barriers they may have encountered. The intervention is based on Social Learning theory as well as the theory of Gender and Power. The SISTA project specifically targets sexually active, heterosexual African-American women.

VDH was fortunate to have staff attend a national training-of-trainers so that VDH can train providers here at home at reduced costs. Virginia has trained 42 women to serve as SISTA facilitators and five contract agencies are currently offering this intervention to women through several of the Division's seven grant programs. Further expansion of SISTA is limited only by availability of funds.

The African-American Faith Initiative (AAFI) was established in 1999. Three faith-based institutions are funded to support an array of interventions for their congregations and surrounding communities including a federal women's correctional facility. Two faith-based models, ***Keeping It Real,*** which provides youth with information on sex and sexuality with a biblical perspective, and ***Breaking the Silence***, which targets adults with information on sex and sexuality so that they may be better prepared to have open dialogue with youth, are utilized. Because faith-based models are limited, other curricula such as ***Be Proud, Be Responsible, SISTA*** and ***Unmasking Sexual Con Games*** have been incorporated into some of the faith-based programs. Via a continued partnership with a local university's school of theology, one of the contractors offers a formal HIV/AIDS ministry course as an elective to clergy persons. This course includes 18 hours of class time, a 22-hour practicum with an AIDS service organization and provision of workshops in area churches. Finally, contractors also utilize, ***The Heart of the Matter***, a curriculum developed by The Balm in Gilead, the leading African-American, faith-based HIV service organization in the U.S.

The contractors establish rapport with other faith communities, hold clergy forums and encourage the heads and lay leaders of those faith institutions to develop HIV/AIDS programs within their houses of worship. HIV conferences and youth retreats are also conducted.

VDH has provided training on *Keeping it Real*, *Breaking the Silence* and *The Heart of the Matter* for several years. In 2005, VDH convened its first four-day clergy workshop for the African-American community. As a result of that training, 12 churches initiated or expanded education and support ministries for their congregations.

Current funding for the AAFI program is $127,900. Through redirection of existing funds, the grant program will be increased to $185,000 in 2007 so that one additional project

may be funded. In 2005, this program reached 4,415 participants. AFFI is an important venue for using the strengths of community and church leadership to reach Black women who might not otherwise see themselves at risk for HIV or participate in HIV prevention programs. However, limited funding has prevented expansion to all areas in need across Virginia.

Expansion of HIV Testing

The CDC estimates that more than one million people in the U.S. are now living with HIV, and approximately 25% are unaware of their HIV infection. Historically, African-Americans are more likely to find out they have HIV late in the disease process (i.e. at the time of AIDS diagnosis) than are Whites.[14] African Americans with AIDS have shorter survival rates than other races and ethnic groups with AIDS, due in part to late diagnosis. Testing for HIV earlier in the disease process means that early medical follow-up and treatment can prolong both the length and quality of life. From 2000-2001, VDH conducted a pilot of oral swab HIV testing in street and community-based settings. No blood draws or needles enables testing that can occur outside the clinical setting. Testing became available to people in their communities removing barriers such as travel, and taking time from work to attend a clinic. Results showed that a greater percentage of Blacks were tested in the community model that in traditional clinical settings. In addition, the positivity rate of those tested was almost double that of STD clinics, indicating that agencies were testing individuals at high-risk who would not have come into the health department for an HIV test. In late 2001, VDH began funding CBOs to target testing to MSM, IDU, sex partners of their groups, high-risk heterosexuals, etc. with emphasis on providing services in communities of color.

Since 2003, CDC has promoted its ***Advancing HIV Prevention Initiative (AHP)*** which calls for increased testing in medical settings, use of new test technologies, testing in jails and ensuring the provision of prevention services with those already infected. When people learn their HIV status and are linked into both care and prevention services, they are less likely to engage in risk behaviors that can transmit HIV to others. Therefore, the more people who learn their HIV status, the quicker we can intervene to prevent disease transmission.

In response to AHP, VDH added the new rapid, 20-minute HIV test to its community-based testing operations in 2004. This program reduces barriers to HIV testing services for many African-American men and women. People who test negative do not need to return for their test results. Those who test preliminary positive can be immediately linked into health care services while their confirmatory test is pending. The immediacy of the test results greatly reduces the anxiety experienced by clients and has encouraged more people to request HIV testing in agencies in which the rapid test is offered.

The cost of both the oral and rapid test ($18 and $13 respectively) compared to a traditional blood test ($2.50), limits its expansion to all the venues and communities where it could be most beneficial.

Public Information

National Black HIV/AIDS Awareness Day (NBHAAD) has been recognized annually on February 7th since 2000. The primary goals of NBHAAD are to motivate African-Americans to get tested and know their HIV status, get educated about the transmission modes of HIV/AIDS, get involved in their local community, and get treated if they are currently living with HIV or are newly diagnosed.

National HIV Testing Day, June 27th, was created by the National Association of People with AIDS in 1995. The goal is to reach the 180,000 to 280,000 Americans who do not know they are HIV-infected and to encourage people to take responsibility for their health and their life. The campaign slogans are "Take the Test and Take Control" and "It's Better to Know".

VDH acts as the statewide coordinator for these awareness days, publicizes local events, and issues press releases and fact sheets. The Division of Disease Prevention always includes focus for National HIV Testing Day on African-Americans and purchases radio ads, bus posters and billboards to reach African-American communities. In 2005, during the two-week Testing Day campaign, calls to the Virginia HIV/STD and Viral Hepatitis Hotline increased 128% compared to the average number of calls and HIV testing increased by 45% across the state.

The Division has no budget line items to support these awareness days. The Division requests carry-over dollars from CDC to support the current year's activities. In some years, however, carry-over funds are not available, leaving the campaign status uncertain from year to year. The last major public information campaign targeting African-Americans occurred in 1997, when federal funds were allocated to support the "It's Your Body. Respect It! Protect It!" campaign. Citizens commenting at public hearings frequently request additional pubic information campaigns, reporting communities have "AIDS fatigue" and have grown apathetic thinking HIV is no longer a problem.[15] Competing requirements from CDC to implement rapid testing, additional Prevention for Positives programs, the DEBI interventions, many of which are expensive to conduct, and a new national Program Evaluation and Monitoring System have presented barriers to developing another statewide campaign.

Unmet Need

At the end of 2005, the Division of Disease Prevention ended its first grant program, the regional AIDS Service Organization Grants, in response to three consecutive years of federal budget rescissions. This impacted prevention services for a number of high-risk populations, most significantly African-American women, incarcerated and rural populations.

Federal funding for Virginia's HIV prevention program has decreased by $320,000 since 2001. VDH funding to support community-based organizations has decreased by $355,000 during that time. Although central office positions have been eliminated, and both planning and research funds have been significantly reduced, the redirection of funds to support increasing operating costs such as rent, personnel, rapid testing technology etc., has inevitably had the greatest impact on direct services. In 2001, the Division supported 51 contracts through 39 agencies for prevention services. In 2006, due to both funding decreases and the increasing costs

of conducting more sophisticated interventions, the Division supports only 40 contracts through 21 agencies.

In 1989, the Virginia General Assembly created the AIDS Services and Education (ASE) Grants Program to support HIV prevention and support services among hard to reach populations. In 1989, ten agencies were funded through this program. The initial $200,000 allocation has not been increased since its creation 17 years ago. In 2004, ASE supported seven programs, three of which specifically targeted Black women. In 2005, funding was redirected to support three demonstration projects to address areas that represented the greatest gap in services; however, none of these projects specifically targets African-American women.

Looking Forward

NHBS: The National HIV Behavioral Surveillance (NHBS) System is an extensive multi-year surveillance project sponsored by CDC. Findings from NHBS will be used to enhance understanding of risk and testing behaviors, and to develop and evaluate HIV prevention programs that provide services to these groups. The Norfolk Metropolitan Statistical Area in Virginia is one of 25 sites nationwide that is participating in NHBS. NHBS activities are implemented in multiple cycles with each cycle targeting a specific risk group and lasting at least a year. During the first cycle, project activities focused on men who have sex with men (NHBS-MSM), the second cycle focused on injecting drug users (NHBS-IDU) and the current cycle that started in January, 2006 focuses on heterosexuals at risk of HIV infection (NHBS-HET).

Each selected site uses CDC guidelines and protocols to recruit participants into the study. The objectives of the project among the populations at risk are to determine sexual and drug risk behaviors, assess HIV testing behavior and to assess exposure to, impact of, and missed opportunities for HIV prevention

The findings in the NHBS Heterosexual cycle will assist in focusing local prevention efforts towards populations who now constitute a majority of new HIV infections and will also assist in focusing local prevention efforts towards racial and ethnic minority populations who now constitute a majority of new HIV infections. This cycle will provide important data on the risk and prevention behaviors of men and women in minority communities at risk of HIV infection.

Social Networking Testing: In the June 24, 2005 issue of the Morbidity and Mortality Weekly Report, CDC reported on a demonstration project in which nine organizations used social networking to identify and test individuals at high risk for HIV.[16] The strategy involves having HIV-infected people and uninfected people at high risk for HIV bring partners and friends at-risk in for testing. Agencies using social networking found positivity rates six times higher than traditional testing methods. Social networking testing may be very effective for offering HIV testing to African-American men and women who have not previously been tested and has been found to be effective in rural areas where no “high-risk venues” can be identified.

Conclusion

The Division continually strives to identify strategies to reduce HIV among Virginia's Black women and looks for opportunities to partner with communities at risk to identify the most effective prevention programs. In order to combat HIV in Black women, programs must be targeted to men and women, as well as take into consideration the social, environmental and cultural context of women's lives. Despite tremendous advances in treatment options and survival rates, HIV remains a major threat. Its economic and human costs are devastating America's Black communities. In the absence of a cure or vaccine for HIV, prevention remains the most effective public health strategy to eliminate the spread of this disease.

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